

Application For Crime Victim Compensation

Arkansas Crime Victims Reparations Board

323 Center Street, Suite 200 Little Rock, Arkansas 72201 (501) 682-1020 or 1-800-448-3014

This application distributed

Claim No.

Social Security

by: Arkansas Attorney General Mike Beebe

Home Telephone

Number

Work Telephone

(Application revised February, 2004)

This application to the Crime Victims Reparations Board must be completed in its entirety. Incomplete applications may be returned
without being processed. If you need assistance completing the application, please call the Attorney General's Office at 1-800-448-
3014 or (501) 682-1020. You do not need to be represented by an attorney to apply for or receive benefits from the Crime Victims
Reparations Board. All correspondence will be sent to the below-listed address unless you specify that an alternate address and phone
number should be used. Please notify our office if your address or phone number is changed.

■ Section A – Vi	ctim/Applicant inform	ATION (A separate application	on must be completed for each victim.)
Victim's Name (M/D/Y)		Sex	Date of Birth
		M/F	
Mailing Address Incident		City/State/ZIP	Age at Time of
Home Telephone Number	Work Telephone	Marital Status	Social Security
Has the Victim ever been c	onvicted of a felony? If yes, in what s	at state and county? Briefly of County	explain conviction (month/year/offense)
The above person is listed	as Victim because:		
They suffered a personal in	jury or death as the result of a viol	lent crimeYesNo	
They are the dependent or	child (including by adoption) of a v	victimYesNo	
They are the spouse, parent,	child, sibling, or grandparent of a dec	ceased victim, child victim, or vic	etim of sexual assaultYesNo
They resided—at the time	of the crime—in the same permane	ent household as a deceased vict	timYes _No
•	•	No	
**This information about t	he Victim will be used for statistical	al purposes only and is needed t	o comply with federal regulations.
Race:WhiteAfrica	an AmericanHispanic or Latino	American Indian/Alaska Na	tiveAsianPacific Islander
Referred to Reparations Bo	pard by:Victim-Assistance Work	kerProsecutorH encyPoster/Brochure	HospitalFuneral Home
Other	Law-Emolection Ag	elicyroster/brochare	_wedia
Complete this section only	if you are submitting this applicat	ion but are different than the pe	erson listed above.
Applicant's Name Victim	Sex	Date of Birth (M/D/Y)	Relationship to
	M/F		
Mailing Address Incident		City/State/ZIP	Age at Time of

Marital Status

()	()					
Has the Applicant ever been convi No Yes	cted of a felony? If	f yes, in what sta State	te and county? County	Briefly explain	n conviction (mo	nth/year/offense)
Contact person other than Victim Name	or Applicant: Add	lress				phone)
■ Section B – Crime	- Information					
NOTE: You must attach a copy	of the law-enforce	ement agency's	incident repor	t to this applic	eation.	
Type of crime:						
Domestic Abuse (Spouse)		Assault (No	on-Family)		Adu	lt Sexual Assault
Child Sex Abuse by Famil Abuse	y Member	Child Sex A	Abuse by Non-F	Samily Member	Chi	ld Physical
Homicide	_	DWI / Hit a	and Run		Othe	er
Did the victim submit to a sexual a	assault examination	n?Ye	s No			
Name and address of hospital:						
Date crime occurred	Date crir	me reported		Time crime	reported	
Address where crime occurred:				County:		
Brief description of crime:						
Was the crime reported to the prop	per authorities with	nin 72 hours?	Yes _	No		
If	no,		ex	kplain		why
Agency to which reported:						_
Address:				Telephone:	()	
Name of agency representative, ca	seworker, or perso	n handling case:				
Who reported		incident	to	the	proper	authorities?
Name of assailant or perpetrator as	nd accomplices (if	known)				
Did the victim know offender?						
Was the victim living with the offer						
are recall firing with the office	, we the thine Of	in moracin;	105	110		
Has the offender been charged in o	court?	Yes	No			

If yes, court case #:	Whi	ich court?	
Have you filed, or do you intend to file, a civil law suit?	Yes	No	
If yes, attorney's name/address:			

■ Section C -	- Reques	t for Medic	al Treati	ment/ Me	ntal-Hea	alth Co	unselir	ng
☐ Check here if t	his section (does not apply	to this Vic	tim/Applicar	nt at this ti	me.		
NOTE: In addition bills, or other statem		•	ou must atta	ch copies of a	ll itemized	medical b	ills, mental	-health counseling
I am seeking compens	sation for:							
Medical Care etc.)	_ Dental Care	Mental-He	alth Counseli	ng Repla	acement Ser	vice Loss	(child care,	, convalescent care,
Eyeglasses, hearing	g aids, or other	r medically neces	sary devices	for the health	of the victim	1		
List any	physical	disabilities	the	victim	had	before	the	victimization:
Briefly desc	cribe	injuries	that	resulted	fro	om	the	victimization:
List all medical expen ambulance fees, and p NOTE: Statements o Provider's Name	orescription me or bills must b	edication costs. A	ttach itemize	d statements o	r bills that y sed.		ceived to d	O 1
Attach additional shee	ets if necessary	v. Will there be a	dditional med	lical bills? _	Yes		No	Unknown
Were any of the bills I	paid or will the	ey be paid by any	of the follow	ring sources?				
Source Yourself		Yes No	\$_	Amount Pai			tification N	
Private Health Insurar	nce		\$					
Medicare/Medicaid	_							
Workers Compensation	on _		\$					
Veterans Administrati	ion							
Auto Insurance	-		\$_					
Restitution/Civil Reco	overy		\$					
Name of Health Insur	er:			Pol	icy Number			
Address:					lephone: (
Name of Auto Insurer					licy Number			

Address:	Telephone: ()	

■ Section D—Rec	•	_	im/Applicant at this time.				
most recent pay stub from three (3) years so lost wage	your employer. If you es can be most accurate	are self-emplo ely determined	yed, you must furnish copies	incident. Attach a copy of your sof your tax returns from the last complete name and address of tillity statement.	it he		
Do you wish to file for work loss? Yes No							
Employer's Business Name			Contact Person/Phone No.	·			
Mailing Address			City/State/ZIP	т.			
How many total days were r	to crime related injurie	S: From:	atal hours were missed?	To: Hourly wage?			
Do/did you receive compens	ation while off work? _	Yes	No If Yes, complete	e the following:			
	Amount pe	r week	From (date)	To (date)			
Workers Compensation	\$						
Unemployment Compensation							
Work Loss Insurance	\$						
Vacation	\$						
Sick Leave	\$						
Union/Fraternal Insurance	\$						
Other	\$						
■ Continu F Do	at fau Faa	nal/Dunial	Fymanaa				
Section E—Rec	•		EXPENSES im/Applicant at this time.				
		-					
			th certificate with this appli	cation.			
Are you seeking funeral ben	efits for a deceased vict	im?	Yes No				
Name of funeral home)			
Mailing Address							
Total amount of funeral bill	\$		Have the funeral expenses b	een paid? Yes	No		
Were funeral expenses paid	by any of the following	? If yes, please	list the amounts paid from ea	ch of the following sources:			
	urial Insurance	Life Insuranc	•	•			
3		\$					
	•	uals Nam	e/Relationship/Mailing Addre	ess of Family Member or Individu	al		
\$\$					—		
Burial/Life Insurance Comp	any			Policy #			
)			
				o victim:			

	ot of any benefits from	the Social Security Admini	istration. Y	You must also provide verification ou must be the legal guardian of a f guardianship.
Are you requesting loss of supp	port that resulted from the	e death of the Victim?	Yes	No
	is loss of support must b	e the guardian of any depen-		vere employed at the time of the hich you are requesting benefits.
Dependent's Name	Date of Birth	Social Security Numb	oer	Relationship to Victim
Do/did you receive income from	n any of the sources liste Amount per mo		S	_ No
Social Security	\$			
Welfare	\$			
Aid to Dependent Children	\$			
Social Security Disability	\$			
Other	\$			
■ Section G—Requ ☐ Check here if this sect				-
NOTE: Only survivors/depersupporting documentation materials			ce with cri	ne scene clean up. Receipts or
the crime or the processing of t	the crime scene. Reasona aste removal. The location	ble expenses include, but ar n of a crime scene may inclu	e not limite ade a structi	rt, stains, or other debris caused by d to, cleaning supplies, equipment ure or automobile; however, a ed.
rental, labor, and hazardous wa distinction exists between clear			Y	es No
distinction exists between clear	at for expenses incurred d	luring crime scene clean up?		

There may be other expenses eligible for reimbursement from the Arkansas Crime Victims Reparations Board. You may wish to speak with a representative of the Board to determine whether your unique expense is eligible for reimbursement. Other expenses that may be eligible for reimbursement include, but are not limited to:

- Purchase and installation of locks and windows following a sexual assault or act of domestic abuse occurring within the victim's primary residence.
- Travel and lodging resulting from a criminal justice proceeding related to the victimization.
- The application for guardianship of minors following the death of a victim.

ALL APPLICANTS MUST SIGN

(Read Before Signing)

CERTIFICATION OF APPLICATION: I hereby certify, subject to the penalty of fine and imprisonment, that the information contained in this application is true and correct to the best of my knowledge. I understand that if I knowingly file a false claim or provide false information or fail to provide material facts or circumstances necessary to substantiate the claim, I may not at a later date file a correct claim. NOTE: A.C.A. §16-90-704 and ACVRB Rule No. 16 provide that filing a false claim for reparations shall constitute a Class D felony.

REPAYMENT OF CRIME VICTIM'S COMPENSATION AWARD: You must repay the Crime Victims Reparations Board if you receive payments from the offender (restitution or civil action), insurance, or any other government or private agency as reimbursement for this injury or death after receipt of payment from the Reparations Board.

SUBROGATION AGREEMENT: I hereby agree to notify the Arkansas Crime Victims Reparations Board in the event that additional benefits become available to me in payment of the same expenses for which I receive reimbursement from the Crime Victims Reparations Board. I further agree to retain, as trustee for the Crime Victims Reparations Board, so much of the recovered funds as necessary to reimburse the Reparations Board to the extent of the compensation awarded to me.

X	
Signature of Applicant/Claimant	Date
Relationship to victim if applicant/claimant is other than victin	m
***	***

IMPORTANT NOTICES

SUPPLEMENTAL RULE - In accordance with ACVRB Rule No. 24, please be advised that additional expenses (called supplemental expenses) that are submitted to the program in the event that a claim is awarded, must be submitted within one year from the date of treatment or payment by a collateral source in order to be considered.

FINANCIAL OBLIGATION REQUIREMENT - In accordance with ACVRB Rule No. 25, please be advised that payments shall not be disbursed on an eligible claim if the victim/claimant owes a financial obligation ordered or imposed as a result of a criminal conviction. Such financial obligation includes parole and probation fees.

MAXIMUM LIMITS - In accordance with Arkansas Code Annotated 16-90-702, the maximum reparations allowed for eligible victims is \$10,000. However, for those victims whose injuries are catastrophic and result in a total and permanent disability, the maximum reparations allowed is \$25,000. In addition, the Board has established ceilings on eligible expenses through their Rules and Regulations.

The Crime Victims Reparations Board acknowledges no responsibility for the expenses submitted to the program until a final decision has been made on a claim and the victim/claimant has complied with any conditions made by the Board. As there is no guarantee of payment by this program, a victim/claimant is responsible to service providers for the expenses that have been incurred as a result of a victimization. In addition, it is the victim/claimant's responsibility to notify service providers of the Board's decision on a claim.

AUTHORIZATION TO RELEASE INFORMATION

For Office Use Only: ACVRB Claim #	Victim:
I voluntarily authorize disclosure (including by paper,	oral communication, and electronic interchange):
notes, x-rays, operative reports, lab and medication recordabout me including medication history, diagnosis, testing including HIV, Acquired Immune Deficiency Syndrome disease or disorders; sexually transmitted diseases; gene alcohol, or other substance abuse information, including	in a patient file, medical records or elsewhere, including any charts ords, copies of all prescriptions, and all other medical information and test results, prognosis, and treatment of any physical condition (AIDS) or other related syndromes or complexes, communicable tic information and test results, domestic abuse information; drug information about treatment or therapy; mental, psychiatric or lans and medications prescribed (including notes by a mental healthing private therapy sessions).
other organization, institution or person who has treated r	practitioner, clinic or other medical or medically related facility, one or consulted with other providers regarding my health during the ecords relating to my victimization but should not be considered as
III. TO WHOM: Agents or employees of the Attorney "Crime Victim's Program."	General's Office Crime Victim's Reparations Program (hereafte
IV. FOR WHAT PURPOSE:	
V. EXPIRES WHEN: [One year after the date shown by	pelow.]
 Reparations Board at 323 Center Street, Suite 66 source of the information disclosed, such as my doctor information already has disclosed the information to the Any agreements I have made to restrict my protected the persons and organizations identified above to release the persons and organizations identified above to release the health care provider or health plan subject to the based on my failure to sign this authorization. Information disclosed by a provider or health plan content of the plan conte	rization at any time by sending a written statement to Crime Victin 00, Little Rock, AR 72201 or by providing written notice to the or. However, the revocation will not be effective if the source of the
I understand that I, or my personal representative, have the	e right to receive a copy of this Authorization.
Signature of Individual or Personal Representative	Date Required
If Representative give relationship to Individual	
Print Name of Individual	Address of Individual / Street No, City, State, ZIP
Print Name of Representative (if applicable)	Address of Representative / Street No., City, State, ZIP

It is important that you list the names of the providers where expenses have been incurred that are directly related to this victimization and for which you are seeking assistance from the Arkansas Crime Victims Reparations Board. Thank you.